SECTION 12

Other services

Dialysis
Hospice
Clinical laboratory
Outpatient therapy

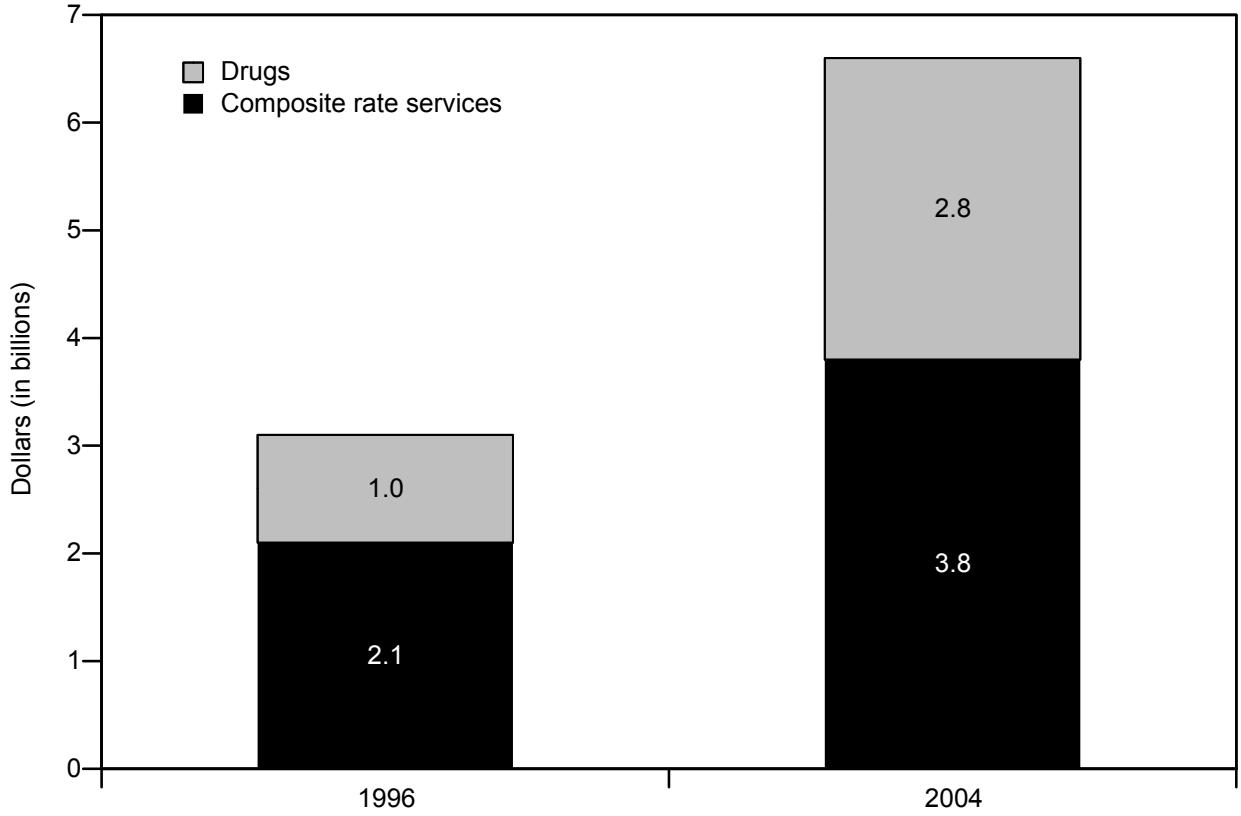
Chart 12-1. Total number of dialysis facilities is growing; for profit and freestanding are increasing over time

	1995	2000	2005
Total number of dialysis facilities	2,721	3,805	4,540
Mean number of hemodialysis stations	15	16	17
Percent of all facilities:			
Urban	76%	74%	75%
Rural	23	25	25
For profit	65	78	78
Nonprofit	35	22	22
Freestanding	74	82	86
Hospital based	26	18	14

Source: Compiled by MedPAC from the CMS facility survey file.

- Between 1995 and 2005, the number of freestanding and for-profit facilities increased, while hospital-based and nonprofit facilities decreased. Freestanding facilities increased from 74 percent to 86 percent of all facilities, and for-profit facilities increased from 65 percent to 78 percent of all facilities.
- Two national for-profit chains own about 60 percent of all facilities and 70 percent of all freestanding facilities.
- Between 1995 and 2005, the proportion of facilities located in rural areas has remained relatively constant.
- While the number of facilities has increased 67 percent since 1995, the mean number of hemodialysis stations per facility has grown more slowly, climbing from 15 in 1995 to 17 in 2005.

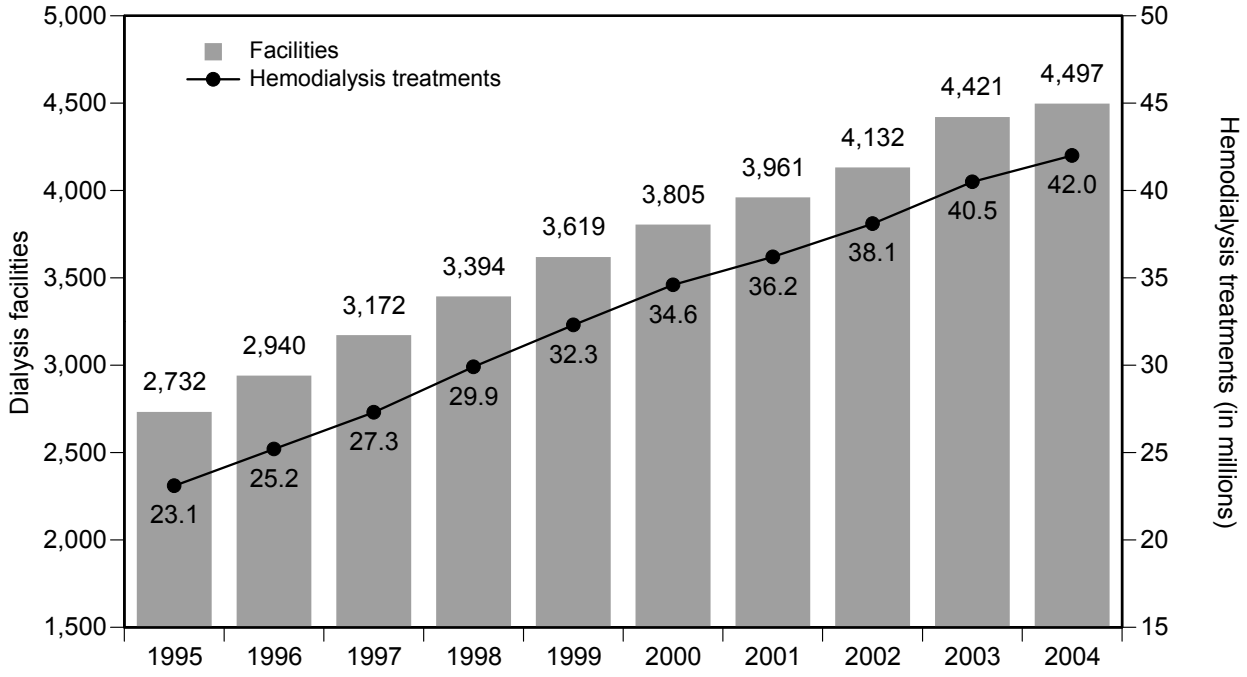
Chart 12-2. Medicare spending for outpatient dialysis services furnished by freestanding dialysis facilities, 1996 and 2004



Source: Compiled by MedPAC from the 1996 and 2004 institutional outpatient files from CMS.

- Between 1996 and 2004, Medicare spending for both dialysis treatments (for which providers are paid a predetermined rate) and for injectable drugs administered during treatments (for which providers are paid on a per unit basis) increased by about 10 percent per year.
- Two factors contributing to spending growth are the increasing size of the dialysis population and the growing use of injectable drugs, such as erythropoietin, iron supplements, and vitamin D analogues.
- The number of dialysis patients increased by 6 percent annually between 1996 and 2004. This growth is linked to a number of factors, including improvements in survival and increases in the number of people with diabetes, a risk factor for end-stage renal disease.
- Between 1996 and 2004, estimated spending for injectable drugs increased by 15 percent annually; in contrast, spending for dialysis increased by 8 percent annually during this time period.

Chart 12-3. Dialysis facilities' capacity increased steadily between 1995 and 2004

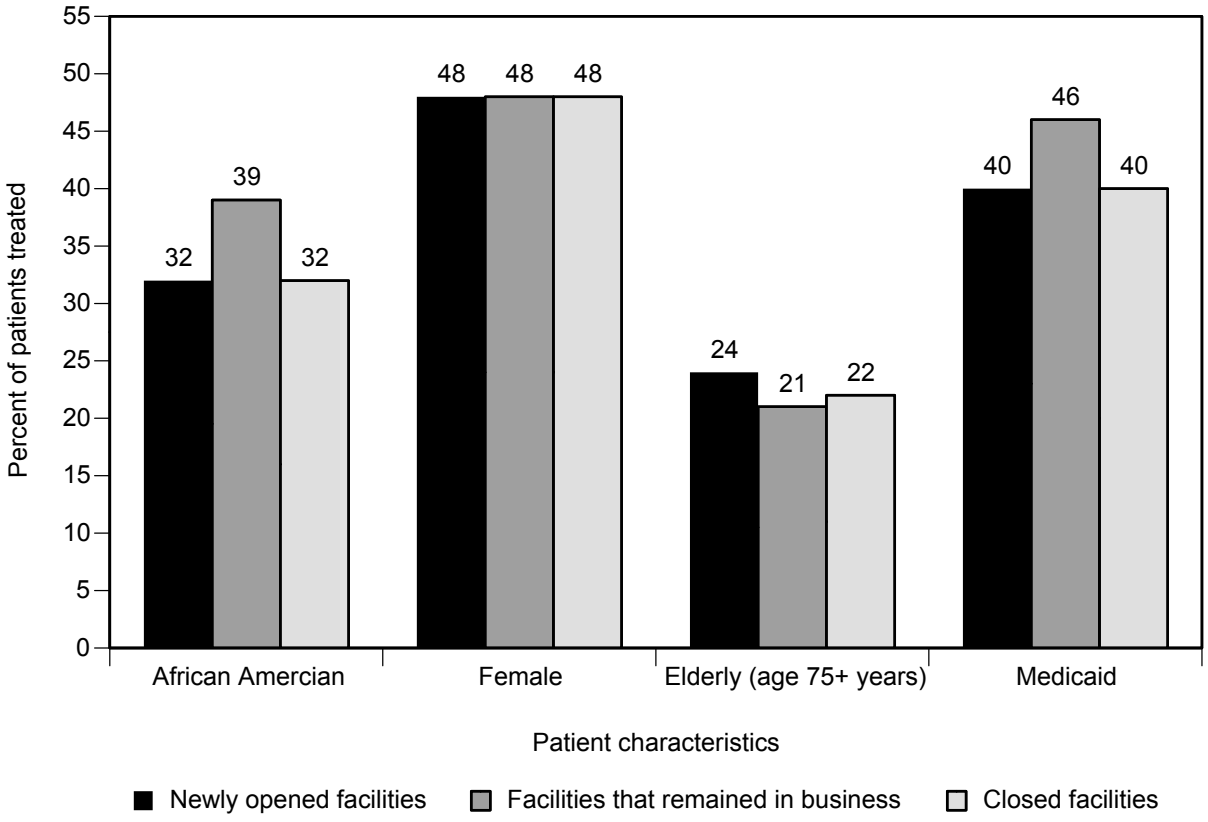


Source: Compiled by MedPAC from the 1993–2004 facility file from CMS.

- Providers have met the demand for furnishing care to an increasing number of dialysis patients by opening new facilities. In 2004, a facility provided about 9,500 treatments per year on average.

- Between 1995 and 2004, the total number of dialysis facilities grew by about 6 percent annually, and the number of hemodialysis treatments grew by 7 percent annually.

Chart 12-4. Characteristics of beneficiaries vary somewhat according to the dialysis facility's business status in 2001 and 2002



Note: The 122 closed facilities are those that were open for business in 2001 but closed in 2002. The 3,752 facilities that remained in business are those that were open for business in 2001 and 2002. The 253 newly opened facilities are those that did not provide dialysis services until 2002. Patients may receive care from more than one facility. A total of 9,296 patients received care at closed facilities; 337,637 received care from facilities that remained in business; and 11,412 received care from facilities newly opened in 2002. Results are weighted by the number of treatments patients received from each facility.

Source: Compiled by MedPAC from the 2005 Renal Management Information System file (the number of dialysis treatments provided to each beneficiary), 2001–2002 denominator files (beneficiaries' demographic characteristics and Medicaid eligibility status), 2000–2003 facility surveys, and 2003–2004 Compare database (facilities' business status and characteristics) from CMS.

- Facilities that stayed in business in both years treated a greater proportion of patients who were African American or dually eligible for Medicaid compared with facilities that closed or were newly opened.
- The characteristics of the patients treated by closed and newly opened facilities were similar—32 percent were African American, nearly half were female, nearly one-quarter were elderly, and 40 percent were dually eligible for Medicaid.
- In 2002, providers' capacity to furnish care increased by 131 facilities and by about 2,000 hemodialysis stations (data not shown).
- These results together suggest that beneficiaries should not be experiencing problems accessing needed care.

Chart 12-5. The ESRD population is growing, and most ESRD patients undergo dialysis

	1994		1998		2003	
	Patients (thousands)	Percent	Patients (thousands)	Percent	Patients (thousands)	Percent
Total	272.3	100%	356.0	100%	453.0	100%
Dialysis	200.4	74	260.4	73	324.8	72
In-center hemodialysis	167.7	62	230.5	65	296.8	66
Home hemodialysis	0.8	<1	1.6	<1	1.3	<1
Peritoneal dialysis	29.5	11	26.8	8	25.9	6
Unknown	2.3	<1	1.4	<1	0.8	<1
Functioning graft and kidney transplants	71.9	26	95.5	27	128.1	28

Note: ESRD (end-stage renal disease). Totals may not equal sum of components due to rounding.

Source: Compiled by MedPAC from the United States Renal Data System.

- Persons with end-stage renal disease (ESRD) require either dialysis or a kidney transplant to maintain life. The total number of ESRD patients increased by 6 percent annually between 1994 and 2003.
- In hemodialysis, a patient's blood flows through a machine with a special filter that removes wastes and extra fluids. In peritoneal dialysis, the patient's blood is cleaned by using the lining of his or her abdomen as a filter. Peritoneal dialysis is usually performed in a patient's home.
- Most ESRD patients undergo hemodialysis administered in dialysis facilities three times a week. Hemodialysis use is growing, while use of the two types of dialysis administered in patients' homes—peritoneal dialysis and home hemodialysis—is declining.
- Functioning graft patients are patients who have had a successful kidney transplant. Patients undergoing kidney transplant may receive either a living or a cadaveric kidney donation. About 40 percent of the kidneys were from living donors and 60 percent were from cadaver donors.
- Medicare is the primary payer for about 80 percent of all dialysis patients and for about half of all kidney transplant and functioning graft patients.

Chart 12-6. Diabetics and the elderly are among the fastest growing segments of the ESRD population

	Percent of total in 2003	Annual percent change 1996–2003
Total (n = 452,957)	100%	5%
Age		
0–19	2	3
20–44	21	2
45–64	43	7
65–74	20	5
75+	16	8
Sex		
Male	55	6
Female	45	5
Race/Ethnicity		
White	61	5
African American	32	5
Native American	1	6
Asian	4	8
Hispanic	13	9
Non-Hispanic	87	5
Underlying cause of ESRD		
Diabetes	36	7
Hypertension	24	5
Glomerulonephritis	16	4
Other causes	23	5

Note: ESRD (end-stage renal disease). Totals may not equal sum of the components due to rounding.

Source: Compiled by MedPAC from the United States Renal Data System.

- Among end-stage renal disease (ESRD) patients, about 35 percent are over age 65. About 60 percent are white.
- Diabetes is the most common cause of renal failure.
- The number of ESRD patients increased by 5 percent annually between 1996 and 2003. Among the fastest growing groups of patients are those who are over age 75 and those with diabetes as the cause of kidney failure.

Chart 12-7. Aggregate margins vary by type of freestanding dialysis facility, 2003

Type of facility	Percentage of all treatment	Percentage of payments from dialysis drugs	Aggregate margin
All facilities	100%	41%	2.4%
Urban	84	41	2.7
Rural	16	42	1.4
For profit	90	41	2.7
Nonprofit	10	38	–0.3
Four largest chains	73	42	3.7
Other chains	14	39	–1.1
Nonchain	12	38	–1.9
Furnishes per year:			
≤ 10,000 treatments	27	42	–2.2
> 10,000 treatments	73	41	4.2

Note: Margins include payments and costs for composite rate services and injectable drugs. Margins are adjusted to reflect MedPAC's analysis of audited cost reports, which found that the ratio of allowable to reported cost per treatment for composite rate services is 95.5 percent.

Source: Compiled by MedPAC from the 2001 and 2003 cost reports and the 2003 institutional outpatient file from CMS.

- For 2003, the adjusted aggregate Medicare margin for composite rate services and injectable drugs was 2.4 percent.
- Aggregate margins vary based on a facility's size, affiliation with the four largest chains, and profit status. This finding stems from differences in the cost per treatment; for example, total cost per treatment was 6 percent higher for independent facilities than for facilities affiliated with the four largest chains. In addition, this finding also reflects differences in the proportion of payments facilities receive from composite rate services, which are less profitable than dialysis injectables.
- Aggregate margins for composite rate services and injectable drugs declined from 5.5 percent in 2000 to 2.4 percent in 2003. During this period the composite rate increased twice, by 1.2 percent in 2000 and 2.4 percent in 2001. In addition, providers' cost per treatment for composite rate services spiked between 2000 and 2002. Although providers' cost per treatment for dialysis injectables increased during this period, the difference between payments and costs remained about the same.

Chart 12-8. Use of hospice among Medicare beneficiaries increased from 2000 to 2004

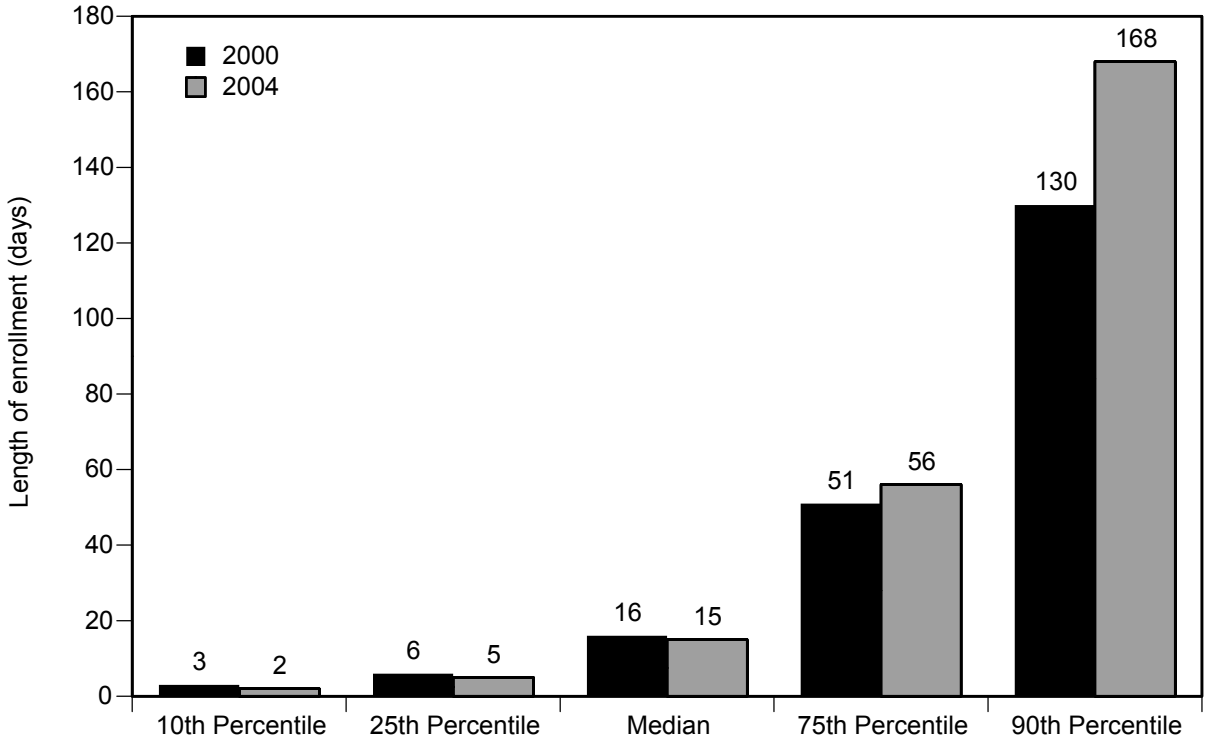
	2000	2004	Percent change 2000–2004
Beneficiaries in hospice	534,261	797,117	49%
Payment (in billions)	$2.9	$6.7	130
Days of care (in millions)	26	52	101
Share of decedents in hospice	22%	31%	N/A

Note: N/A (not available). Data include Puerto Rico.

Source: Share of decedents in hospice from MedPAC analysis of 5 percent Enrollment Database file, 2005, from CMS. Beneficiaries, payment, and days of care from Medicare National Summary for HHA, Hospice, SNF, and Outpatient. http://www.cms.hhs.gov/MedicareFeeforSvcPartsAB/02_MedicareUtilizationforPartA.asp#TopofPage. Accessed February 13, 2006.

- Medicare spending on hospice increased 130 percent to $6.7 billion between 2000 and 2004. The CMS Office of the Actuary estimates that spending on hospice will grow to $9.8 billion by 2006.
- Medicare's spending on hospice services is projected to increase at an average annual rate of 9 percent per year from 2004 to 2015. This growth outpaces the rates of spending growth for hospital, physician, skilled nursing facility, and home health services.
- Over time, more Medicare beneficiaries have elected to use hospice before they die. The rate of hospice use grew from 22 percent of decedents in 2000 to 31 percent in 2004.
- With the increase in the share of decedents electing hospice before they die, the total number of hospice users has increased. Between 2000 and 2004, the number of hospice users increased almost 50 percent and the total number of covered days doubled during that same period.

Chart 12-9. Long hospice stays are getting longer, but short stays persist

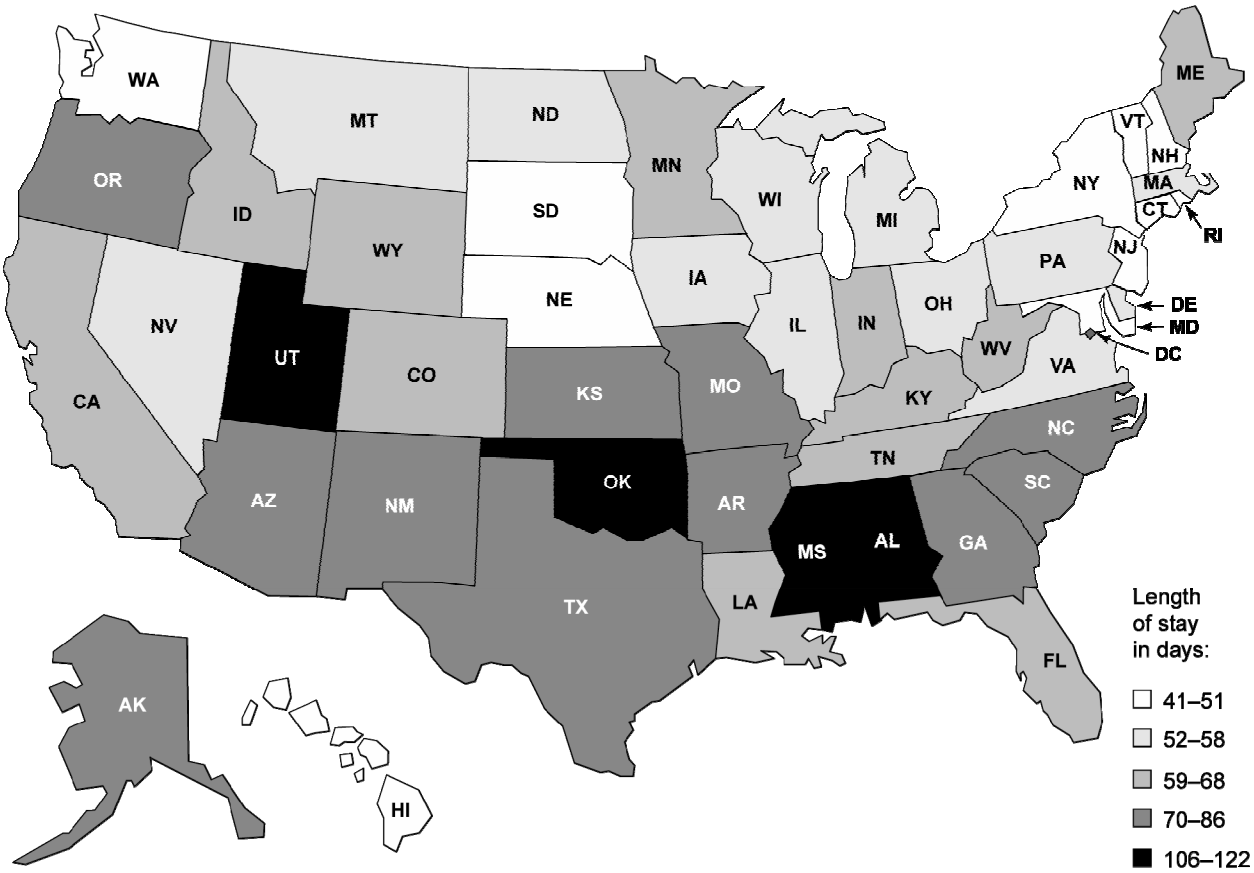


Note: Data are for Medicare beneficiaries in fee-for-service Medicare.

Source: MedPAC analysis of 5 percent Enrollment Database file, 2005, from CMS.

- The increase in the number of covered hospice days outpaced the growth in the number of users of hospices. This trend in driven by increasingly longer lengths of enrollment over time for the share of beneficiaries at the upper end of the enrollment distribution.
- Increasingly longer stays at the upper end of the enrollment distribution drove up the mean length of enrollment between 2000 and 2004, but the median length of enrollment remains at about 2 weeks.
- In 2000 and 2004, more than 25 percent of beneficiaries dying in hospice were enrolled for less than a week before their deaths.

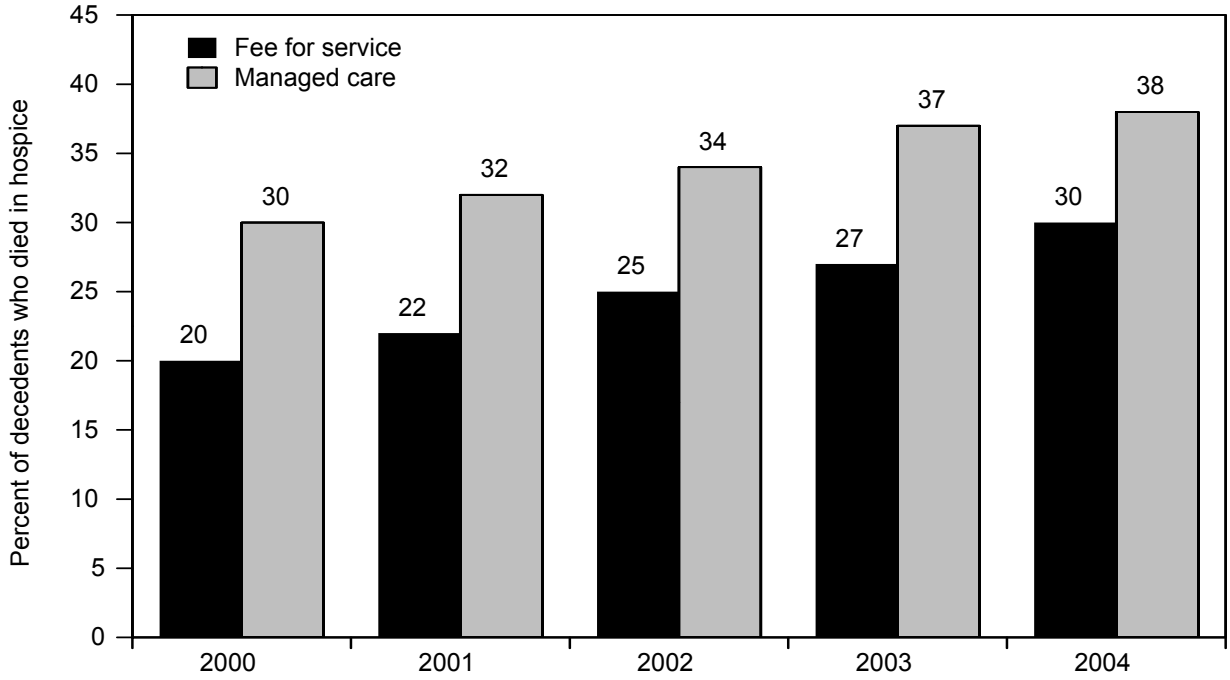
Chart 12-10. Average length of stay in hospice by state, 2004



Source: MedPAC analysis of CMS data from Medicare Hospice Utilization by State, CY 2004. http://www.cms.hhs.gov/MedicareFeeforSvcPartsAB/Downloads/HOSPICE04.pdf. Accessed February 13, 2006.

- Mean lengths of stay in hospice varied widely by state from a low of 41 days in South Dakota to a high of 122 days in Mississippi in 2004.

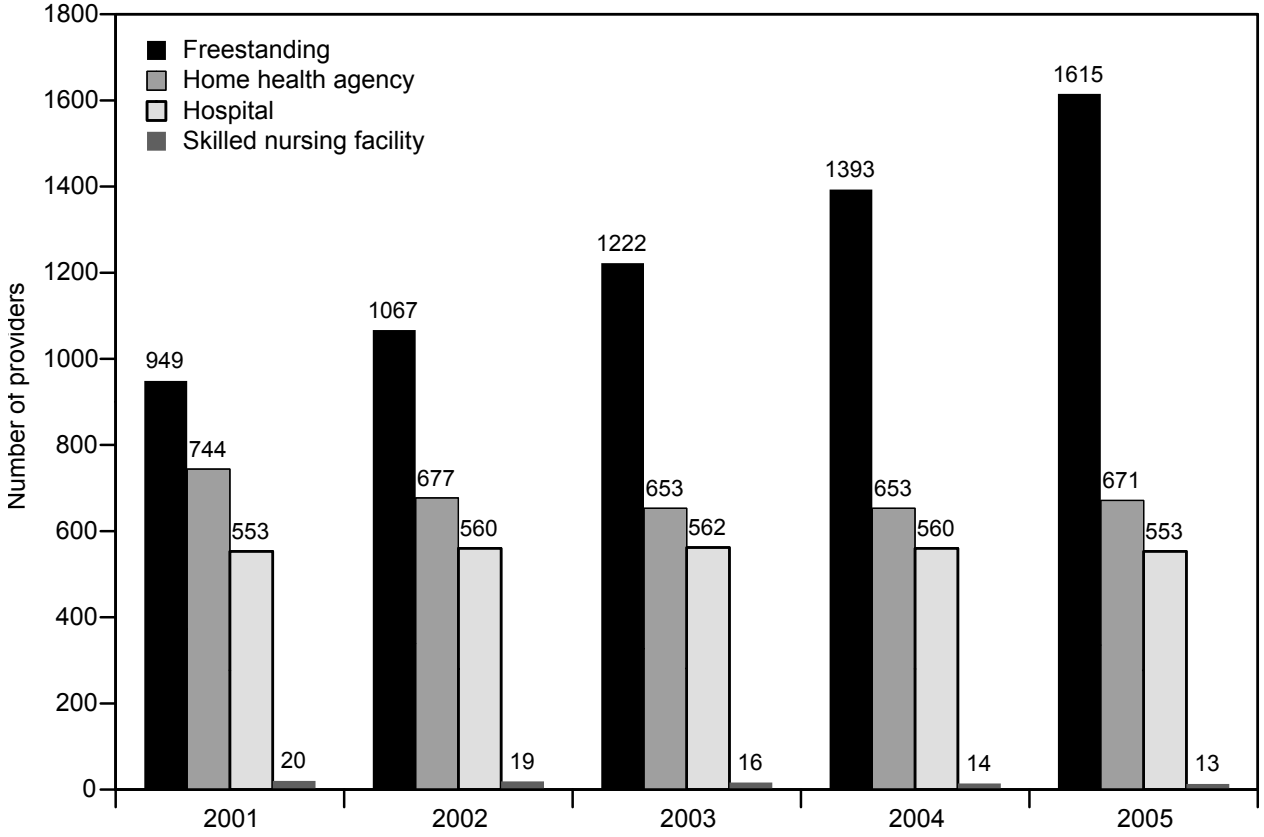
Chart 12-11. Hospice use has grown for all Medicare decedents, but use remains higher among those in managed care



Source: MedPAC analysis of 5 percent Enrollment Database file, 2005, from CMS.

- Among beneficiaries who died, those in managed care were more likely to use hospice care than beneficiaries in the fee-for-service program. In 2004, 38 percent of decedents in managed care used hospice, while 30 percent in fee-for-service used hospice.

Chart 12-12. An increase in freestanding agencies fueled growth in the number of hospice providers, 2001–2005



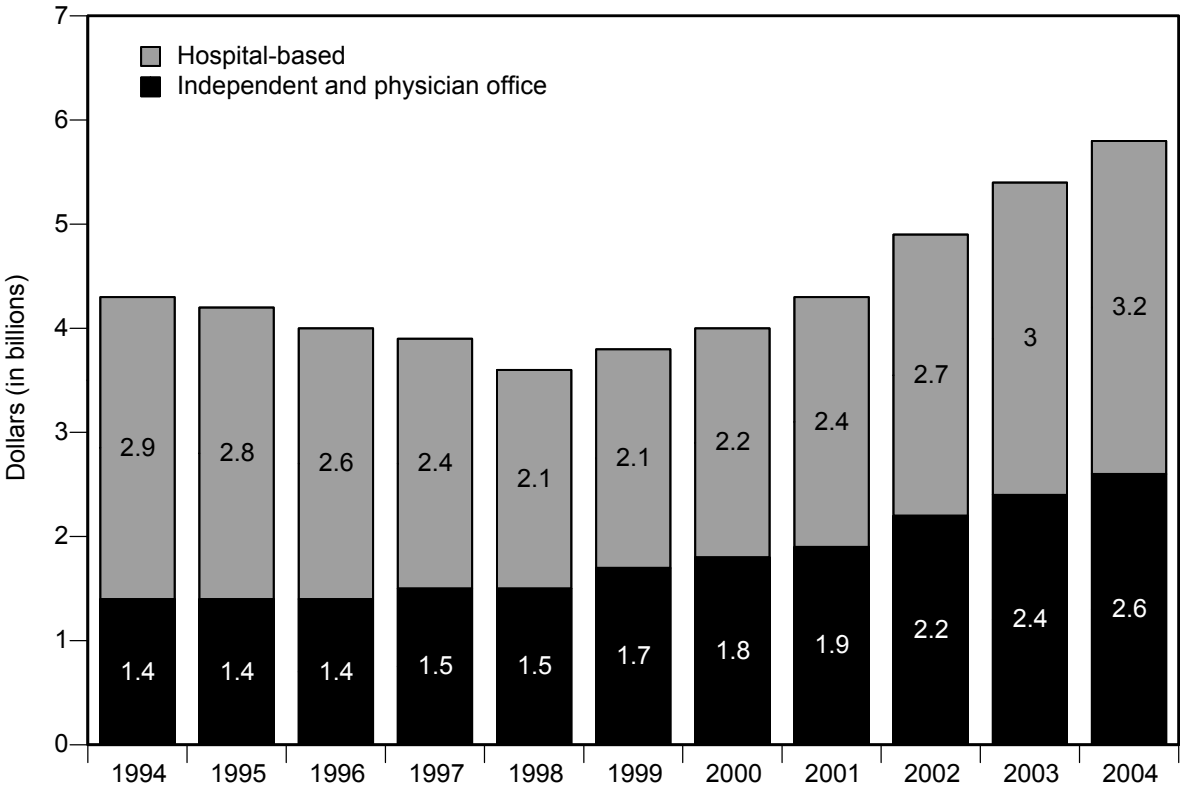
Note: Data for 2001–2005 are as of the end of each calendar year.

Source: MedPAC analysis of unpublished Online Survey, Certification, and Reporting System data from CMS.

- The number of hospice agencies participating in the Medicare program rose 26 percent from 2001 to 2005. This growth is attributable to the growth in freestanding hospice providers, which accounted for 57 percent of hospices in 2005.

- Over time, for-profit hospices have come to take up a larger share of hospice providers (not shown). As of February 2006, 46 percent of hospice providers were for profit, compared to 31 percent in 2001.

Chart 12-13. Medicare spending for clinical laboratory services, in billions, FY 1994–2004



Note: FY (fiscal year). Spending is for services paid under the clinical laboratory fee schedule. Hospital-based services furnished to noninpatients in laboratories owned or operated by hospitals.

Source: CMS, Office of the Actuary.

- Repeated reductions in Medicare's payment rates for clinical laboratory services resulted in declining overall program spending throughout the 1990s, particularly for services furnished in independent and physician office labs. Since 1999, however, growth in volume has caused Medicare expenditures for lab services to climb an average of 9 percent per year.

- In 2004, Medicare payments for clinical laboratory services totaled an estimated $5.8 billion, or 2 percent of total program spending.

Chart 12-14. Hospital and independent laboratories account for most ambulatory test volume

Type of facility	Number of labs	Share of total labs	Share of total test volume	Share of total payments
Physician office labs	104,944	54.5%	17.3%	15.5%
Hospital labs	8,617	4.5	49.3	44.1
Independent labs	5,239	2.7	30.5	37.3
Other	73,683	38.3	3.0	3.1
Total	192,533	100.0	100.0	100.0

Note: Other includes skilled nursing facility labs, home health agency labs, and other labs. Data on number of labs and share of total labs are from 2005. Data on test volume and payments are from 2003. Analysis includes only tests paid under the Medicare clinical laboratory fee schedule; it excludes tests furnished to hospital inpatients and tests furnished to dialysis patients as part of the composite payment bundle.

Source: MedPAC analysis of a 5 percent sample of Medicare claims data and the CMS Clinical Laboratory Improvement Act database.

- The number of labs has grown, on average, about 2 percent per year over the last decade.
- Because some hospitals operate more than one lab, there are more hospital-based laboratories than there are hospitals. Hospital-based labs conduct tests for their inpatients and outpatients and also provide services for nonpatients (referred to as “outreach testing”). Although they account for only 4.5 percent of the nation’s labs, hospital-based laboratories conduct about half of the tests paid under Medicare’s clinical laboratory fee schedule.
- Independent laboratories conduct tests for physicians, hospitals, and other health care providers. Patient samples are frequently taken by other health care providers (in physician offices, hospitals, and other health care settings) and sent to independent labs for analysis, but samples may also be drawn in independent laboratory patient service centers. Although independent labs represent only about 3 percent of all labs nationwide, they furnished 31 percent of tests paid under Medicare’s lab fee schedule in 2003. Independent labs’ share of Medicare payments for tests was even higher (37 percent), consistent with the fact that independent labs are more likely than other labs to provide costly tests.
- Physician office labs represent slightly more than half of all labs, but most (about 80 percent) perform only a few simple types of tests. Thus, physician office labs furnish only 17 percent of the lab services paid under Medicare’s clinical laboratory fee schedule.

Chart 12-15. Highest volume laboratory tests, 2003

Test	Percent of total volume	Percent of total payments	Average annual volume growth, 2001–2003
Complete blood count, automated	8.2%	9.4%	25.0%
Prothrombin time	6.3	3.6	8.3
Comprehensive metabolic panel	5.6	7.4	13.9
Lipid panel	4.7	7.0	11.3
Basic metabolic panel	3.8	4.1	6.9
Assay of thyroid-stimulating hormone	3.1	7.7	11.0
Glycated hemoglobin test	2.3	3.3	13.0
Urinalysis, automated, with scope	1.5	0.7	9.7
Urinalysis, nonautomated, with scope	1.4	0.7	–4.0
Assay of creatinine	1.4	0.5	–2.2
Top 10 tests	38.4	44.5	11.9

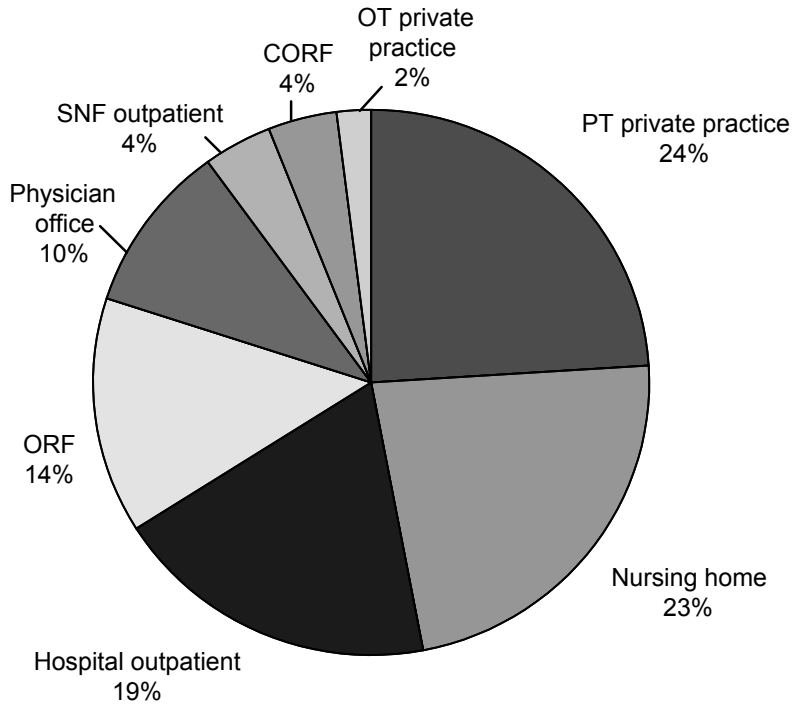
Note: The most frequently provided service on Medicare's clinical laboratory fee schedule is not a laboratory test. Venipuncture, the drawing of blood for a test specimen, accounts for 18 percent of total volume and 6 percent of total payments.

Source: MedPAC analysis of Medicare claims data.

- Although there are more than 1,000 items on Medicare's lab fee schedule, the volume of tests is fairly concentrated, with the top 10 tests accounting for 38 percent of total volume and 45 percent of total payments.

- Five of the highest volume tests—complete blood count (CBC), comprehensive metabolic panel, lipid panel, thyroid stimulating hormone assay, and glycated hemoglobin—grew more than 10 percent between 2001 and 2003, with CBC volume rising at a rate of 25 percent per year. Many of the laboratory tests that are growing rapidly are recommended by clinical guidelines for the treatment of certain chronic conditions. For example, complete blood count tests and metabolic panel tests are quality indicators for congestive heart failure, and the lipid panel and hemoglobin tests are quality indicators for diabetes.

Chart 12-16. Outpatient therapy is furnished by many different entities



Note: PT (physical therapist), ORF (outpatient rehabilitation facility), SNF (skilled nursing facility), CORF (comprehensive outpatient rehabilitation facility), OT (occupational therapist). Based on share of Medicare spending in 2004. PT private practice and OT private practice include therapists employed by physician groups who bill independently and are not furnishing services incident to physician services.

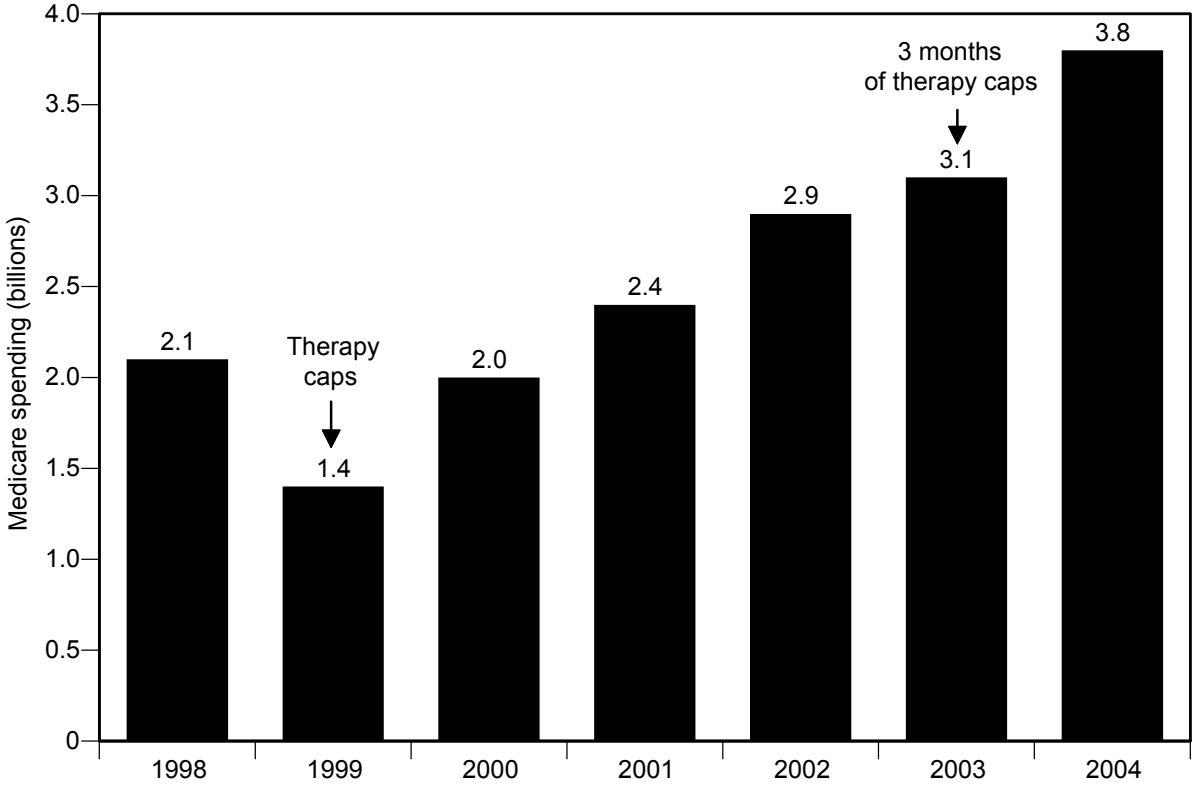
Source: MedPAC analysis of the 5 percent file of carrier and fiscal intermediary claims for 2004.

- Outpatient therapy services are furnished in a variety of settings, both institutional (e.g., nursing homes and hospital outpatient departments) and independent (e.g., therapists' and physicians' offices).

- Services are increasingly provided in independent settings. The share of services furnished in nursing homes and in hospital departments was considerably smaller in 2004 (23 percent and 19 percent, respectively) than in 2002 (30 percent and 24 percent, respectively).

- Services furnished by physical therapists in private practice (which include therapists working for physicians' practices and billing independently) and those provided in nursing homes to long-stay nursing home residents accounted for almost half of outpatient therapy services.

Chart 12-17. Medicare spending on outpatient therapy services has almost doubled since 2000



Note: Therapy caps were in effect for all of 1999 and for three months in 2003.

Source: MedPAC analysis of the 5 percent file of carrier and fiscal intermediary claims for 1998–2004.

- Medicare spending on outpatient therapy services in 2004 was $3.8 billion, up from $2 billion in 2000. This growth was a result of more beneficiaries using therapy services and more services being furnished to each user.

- Spending slowed during 1999, when limits on Medicare payments per beneficiary (the therapy caps) were in place. One therapy cap limited spending per beneficiary for physical therapy services and speech-language pathology services; the other limited spending on occupational therapy services. When first put in place in 1999, each cap was $1,500.

- In January 2006, the $1,500 therapy caps were reinstated. The caps are updated each year for inflation and are currently $1,740. However, as required by the Congress, there is now an exceptions process allowing beneficiaries with high care needs to apply for exemption from the therapy caps.

Chart 12-18. Outpatient therapy users and service have increased since 2000

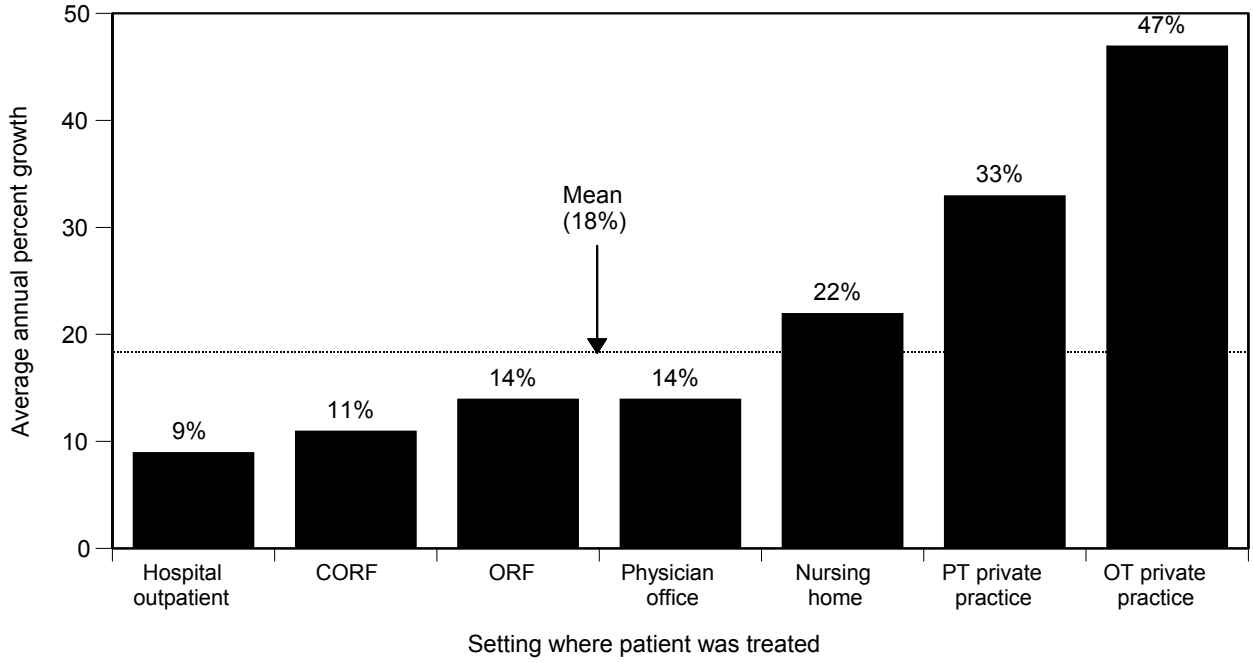
	1998	1999*	2000	2001	2002	2003*	2004	Average annual change 2000–2004
Spending (billions)	$2.1	$1.4	$2.0	$2.5	$3.0	$3.2	$3.9	18%
Users (millions)	3.1	3.0	3.3	3.7	4.0	4.2	4.5	8
Spending per user	$671	$469	$621	$693	$749	$760	$883	9

Note: *Indicates the year in which the therapy caps were in operation (full year in 1999, 3 months in 2003).

Source: MedPAC analysis of the 5 percent file of carrier and fiscal intermediary claims for 1998–2004.

- Medicare spending on outpatient therapy services increased an average 18 percent per year between 2000 and 2004. This rapid growth was the result of both beneficiaries using therapy services and more services being furnished to each user.
- The number of users increased an average of 8 percent per year between 2000 and 2004, much faster than the 1 percent to 2 percent annual growth in the number of beneficiaries.
- Service intensity, as measured by spending per user, increased 9 percent per year during this period. Although fee schedule increases account for some of this increase, the number of units of service billed during this period grew an average of 13 percent per year. Growth in services commonly furnished, not new modalities, drove the increases.

Chart 12-19. Medicare spending on therapists in private practice grew faster than that for other providers, 2000–2004



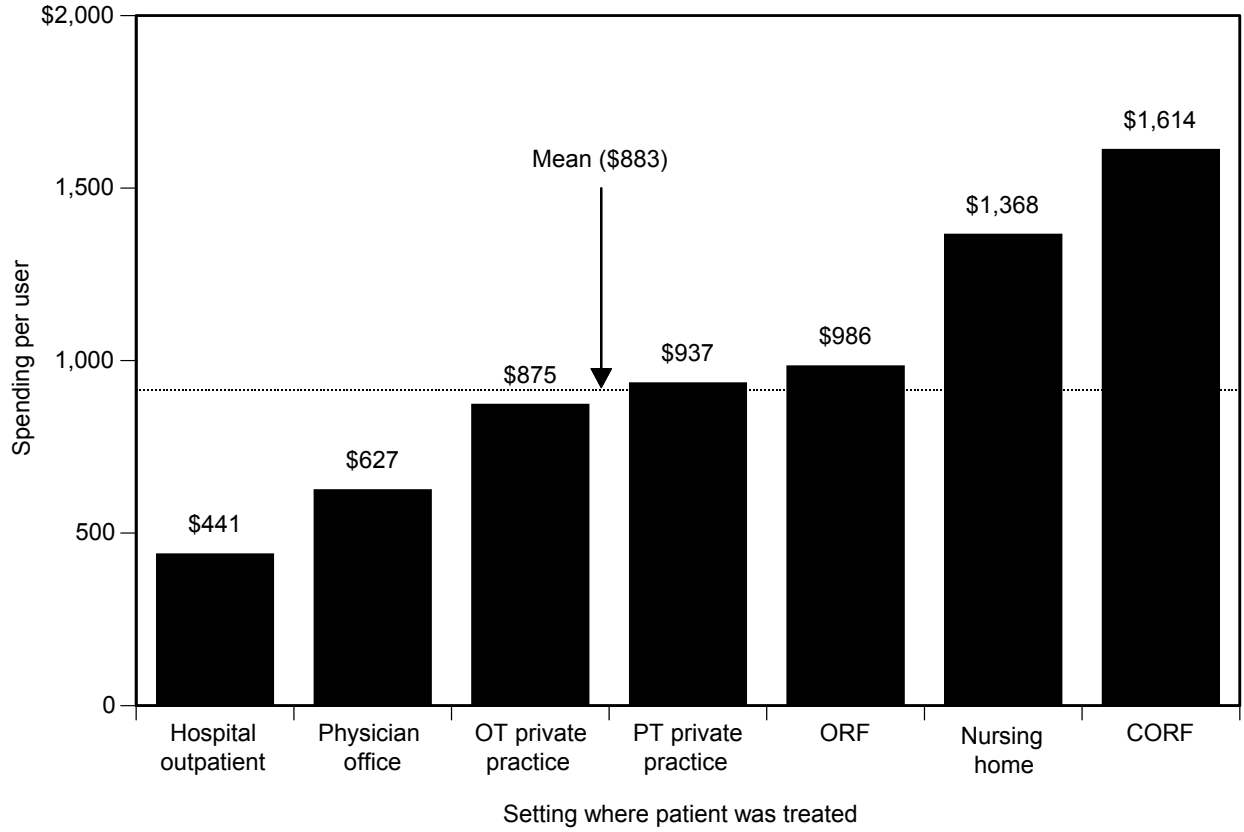
Note: CORF (comprehensive outpatient rehabilitation facility), ORF (outpatient rehabilitation facility), PT (physical therapist), OT (occupational therapist). PT private practice and OT private practice include therapists employed by physician groups who bill independently and are not furnishing services incident to physician services.

Source: MedPAC analysis of 5 percent fiscal intermediary and carrier 2000–2004 claims files.

- Between 2000 and 2004, spending on outpatient therapy grew an average 18 percent a year, but this number varied considerably by provider setting. Spending in hospital outpatient departments grew the slowest, while therapists in private practice (physical and occupational therapists) grew the fastest.

- The number of therapists in private practice who furnished services to beneficiaries more than doubled between 2000 and 2004. Several factors contributed to this growth, including changes in the way therapists were paid in institutional settings, which encouraged them to establish their own practices, and changes in Medicare rules that allowed licensed therapists to bill directly for services they furnished.

Chart 12-20. Per user spending on outpatient therapy varied threefold across settings, 2004



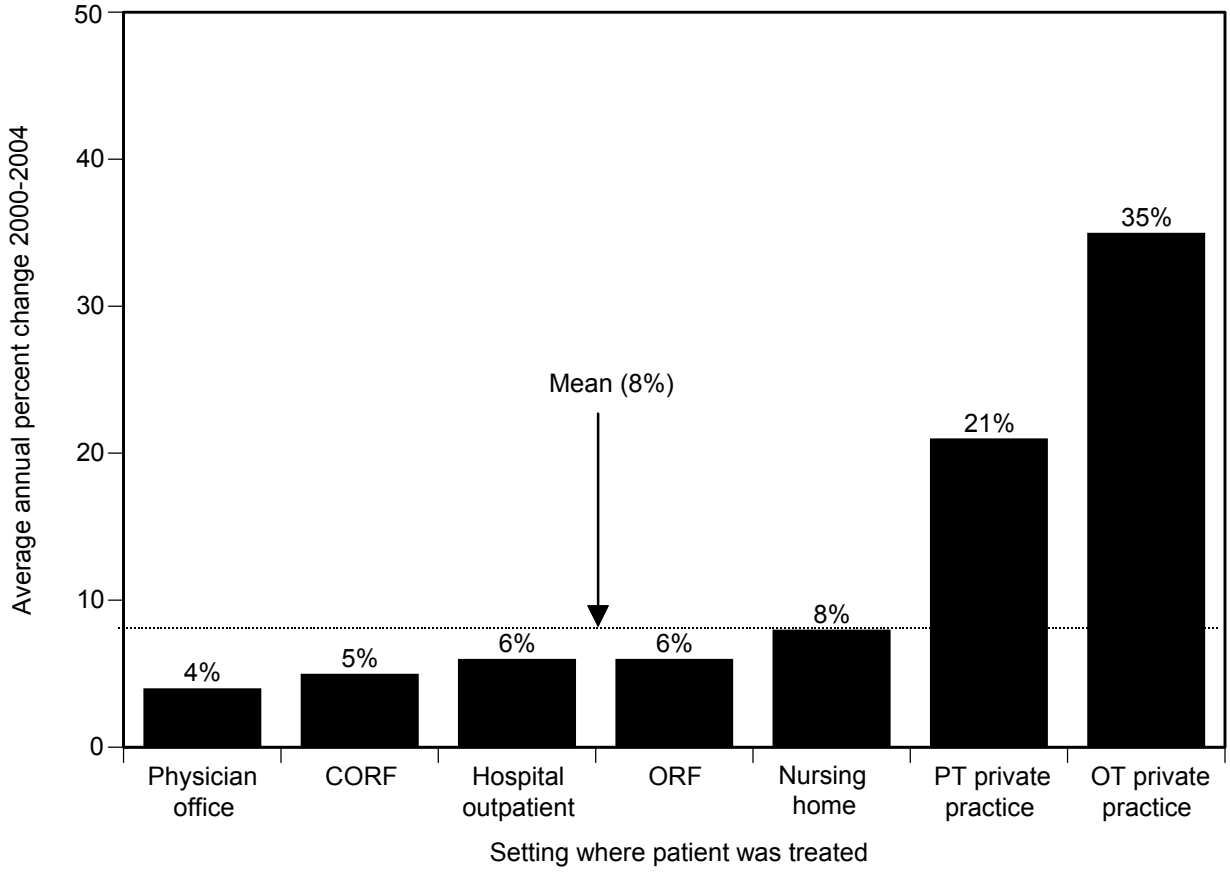
Note: CORF (comprehensive outpatient rehabilitation facility), ORF (outpatient rehabilitation facility), PT (physical therapist), OT (occupational therapist). PT private practice and OT private practice include therapists employed by physician groups who bill independently and are not furnishing services incident to physician services.

Source: MedPAC analysis of 5 percent fiscal intermediary and carrier 2000–2004 claims files.

- In 2004, Medicare spending on outpatient therapy services averaged $883 per user. However, spending varied considerably by setting. Spending was the lowest in hospital outpatient departments ($441) and the highest in CORFs ($1,614). Because payment rates are the same across settings, differences are attributable to the volume and intensity of services.

- There was a twofold variation across states (data not shown). In states with low per user spending, beneficiaries received a higher share of their therapy in hospital outpatient departments compared with states with high per user spending.

Chart 12-21. Since 2000 the number of outpatient therapy users grew 8 percent a year



Note: CORF (comprehensive outpatient rehabilitation facility), ORF (outpatient rehabilitation facility), PT (physical therapist), OT (occupational therapist). PT private practice and OT private practice include therapists employed by physician groups who bill independently and are not furnishing services incident to physician services.

Source: MedPAC analysis of 5 percent fiscal intermediary and carrier 2000–2004 claims files.

- On average, the number of therapy users grew 8 percent per year between 2000 and 2004. The number of beneficiaries treated in private practice grew much faster than average.

- The number of therapists in private practice who furnished services to beneficiaries more than doubled between 2000 and 2004. This growth reflected many policy changes since the late 1990s that allowed therapists to bill independently and encouraged them to establish their practices as private practices.

Web links. Other services

Dialysis

- More information on Medicare's payment system for outpatient dialysis services can be found in MedPAC's Payment Basics series.
  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_dialysis.pdf

- The US Renal Data System provides information about the incidence and prevalence of patients with renal disease, their demographic and clinical characteristics, and their spending patterns.
  http://www.usrds.org

- The National Institute of Diabetes & Digestive & Kidney Diseases and the National Kidney Foundation provide health information about kidney disease for consumers.
  http://www.niddk.nih.gov/
  http://www.kidney.org/

- CMS provides specific information about each dialysis facility.
  http://www.medicare.gov/Dialysis/Home.asp

- Chapter 2C of the MedPAC March 2006 Report to the Congress provides information about the financial performance of dialysis facilities.
  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02C.pdf

- MedPAC's June 2005 Report to the Congress recommends changes to how Medicare pays for composite rate services and injectable drugs.
  http://www.medpac.gov/publications/congressional_reports/June05_Ch4.pdf

- MedPAC's October 2003 report describes how Medicare could modernize the outpatient dialysis payment system.
  http://www.medpac.gov/publications/congressional_reports/oct2003_Dialysis.pdf

- MedPAC's comment on revisions to payment policies under the physician fee schedule for calendar year 2004 includes changes in how to pay for services furnished by nephrologists.
  http://www.medpac.gov/publications/other_reports/100603_RevPhysFeeSched_CB_comment.pdf

Hospice

- More information on Medicare's payment system for hospice services can be found in MedPAC's Payment Basics series.
  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_hospice.pdf

- Additional information and analysis related to the Medicare hospice benefit can be found in Chapter 3 of MedPAC's June 2006 Report to the Congress, available at http://www.medpac.gov/publications/congressonal_reports/Jun06_ch03.pdf

- Chapter 6 of the MedPAC's June 2004 Report to the Congress reviews trends and policy issues for the Medicare hospice benefit.
  http://www.medpac.gov/publications/congressional_reports/June04_ch6.pdf

- The MedPAC May 2002 Report to the Congress: Medicare beneficiaries' access to hospice provides information on beneficiaries' access to hospice care.
  http://www.medpac.gov/publications/congressional_reports/may2002_HospiceAccess.pdf

- Chapter 7 of the MedPAC June 1999 Report to the Congress examines end-of-life care and makes policy recommendations.
  http://www.medpac.gov/publications/congressional_reports/Jun99%20Ch7.pdf

Clinical laboratory

- Information about CMS regulation of clinical laboratories, including the number and type of certified labs in the U.S., can be found on the CMS website.

  http://www.cms.hhs.gov/CLIA

Outpatient therapy

- Chapter 6 of MedPAC's June 2006 Report to the Congress provides information about outpatient therapy services.

  http://www.medpac.gov/publications/congressional_reports/Jun06_Ch06.pdf

- A description of the history and impact of the therapy caps can be found in MedPAC's Payment Basics series.

  http://www.medpac.gov/publications/other_reports/Dec05_Medicare_Basics_OPT.pdf